OFFICE OF SUBSTANCE ABUSE
OUTPATIENT SERVICE DELIVERY FORM
SFY' 05

This form should be completed for each ambulatory service setting the agency is contracted for. Please remember that DSAT clients should be reported separately on their own Outpatient Service Delivery Form.

Contract Number: _____ **Contract Month:** _____

Please circle one: **Non-Intensive Outpatient** **Adolescent Non-Intensive Outpatient**
Intensive Outpatient **Adolescent Intensive Outpatient**
Women's Case Management Services

Are these DSAT clients: **Yes** **No**

Agency Name: _____

Telephone #: _____

Prepared by: _____

Total Program Units Delivered
(Please use 1/4 hour units to report outpatient services
and daily units for intensive outpatient services)

	Primary Month	Affected Month
Individual		
Group		
Use as Appropriate for: Family, Assessment or Case Management		

If you have questions regarding this form, please call the Helpdesk at 287-6337 or email it at TDS.Helpdesk@maine.gov

Please return one copy to:

Mary Beaudoin
Office of Substance Abuse
159 SHS, AMHI Complex
Marquardt Bldg, 3rd Floor
Augusta, ME 04333-0159
Fax: (207) 287-4334
or email: Mary.Beaudoin@maine.gov

Date received by OSA:

Revised: July 14, 2003